Plastic Surgery Associates of Valdosta

230 Northside Drive, Valdosta, GA 31602

229-242-3002 Phone 229-242-0644 Fax

Name _____

(first) (Middle) (Last)

Address _____ Apt # _____ or Lot # _____

City _____ State _____ Zip _____

Cell Phone _____ Alternate Phone _____

Our office utilizes text message appointment reminders. Do you wish to receive appointment reminders via text message? ( ) Yes ( ) No

Social Security # _____ Date of Birth _____ Marital Status ( )S ( )M ( )D ( ) W

( ) Male ( ) Female Race _____ Ethnicity _____

Do you have email? ( ) Y ( ) N Would you like to be added to our mailing list for specials and news? ( ) Y ( ) N

Email Address _____

Are you employed? ( ) Y ( ) N Name of Employer _____ Occupation _____

Address of Employer _____

Spouse's Name _____ Employer _____ Occupation _____

If patient is a minor please provide employment information for responsible party.

Responsible Party (for patients under 18)

Name: _____ Date of Birth: _____ Phone: _____

Do you have insurance? ( ) Y ( ) N

**If your insurance is NOT in your name, we MUST have the following information:

Primary Insurance: _____ Is this an exchange plan: ( ) Y ( ) N

Group Insurance Employer Name: _____

Policy Holder's Name: _____ Policy Holder's Phone#: _____

Policy Holder's Date of Birth: _____ Policy Holder's Relationship to Patient: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

Secondary Insurance: _____ Is this an exchange plan: ( ) Y ( ) N

Group Insurance Employer Name: _____

Policy Holder's Name: _____ Policy Holder's Phone#: _____

Policy Holder's Date of Birth: _____ Policy Holder's Relationship to Patient: _____

Policy Holder's Address: _____ City: _____ State: _____ Zip: _____

I understand that I am responsible for all charges. I will furnish this office with all information necessary to bill by insurance. Any balance after insurance has paid or denied is due by me. I agree that if it becomes necessary to forward by account to a collection agency, I will also be responsible for the reasonable cost of collection, to include attorney fees. I understand that my insurance benefits and referral requirements are my responsibility and that all co-payments and co-insurance are due at the time of service.

I authorize payment of medical benefits to physician for these services and all future claims and I authorize the release of any medical information necessary to process this claim and all future claims.

_____ _____

Signature Date